HOMELESS INITIATIVE POLICY SUMMIT

POLICY BRIEF:

AFFORDABLE CARE ACT OPPORTUNITIES

The Affordable Care Act and related changes in health care financing and delivery systems create opportunities for Los Angeles County and its partners to invest in effective solutions to address homelessness.

10/15/2015

POLICY BRIEF:

Affordable Care Act Opportunities

A large number of homeless individuals with the advent of the Affordable Care Act (ACA) now qualify for full-scope Medi-Cal, including specialty mental health services for those with severe mental illness and substance use disorder benefits. In addition, changes to Medi-Cal already underway and expected in 2016, will create new financing mechanisms and incentives, as well as opportunities for new ways to engage partners, including Medi-Cal managed care plans, to connect people experiencing homelessness to health care, housing, and supportive services in more meaningful ways.

Key Issues

Many homeless people have significant health needs and often co-occurring disorders, and their health needs cross the boundaries of various and often fragmented systems.

- People who experience homelessness also experience high rates of disability and chronic and behavioral health, and substance use disorder (SUD) conditions; and
- People who experience unsheltered homelessness face significant health risks and barriers to accessing appropriate care or managing health conditions. This often results in health-related crises and avoidable emergency room visits, hospitalizations, and readmissions, as well as high rates of mortality and other poor health outcomes.

Two primary aspects of the ACA: 1) it expands coverage and access to care (by reducing the number of Americans who are uninsured); and 2) controls costs of health care by providing better value with the resources we spend on health care. Most significantly for many homeless people, and the systems that deliver health care to them, the ACA expanded Medicaid eligibility by providing federal funding for all (or nearly all) of the costs of delivering covered services to adults who are newly eligible.[1]

The ACA also authorized new optional Medicaid benefits states can use to expand or improve health services for people with complex needs, such as Health Home benefits, and provides significant increases in federal funding to expand the capacity of community clinics to deliver more care to more people. Many provisions

[1] See http://files.kff.org/attachment/fact-sheet-summary-of-the-affordable-care-act.

of the ACA have the goal of transforming health care and delivery systems to achieve the "Triple Aim" of better outcomes, lower costs, and better experience for patients.

With the expansion of Medi-Cal (Medicaid) eligibility under the ACA, nearly all people who are experiencing homelessness in Los Angeles are eligible for Medi-Cal (with some exceptions based on immigration status). California mandates enrollment of almost all Medi-Cal beneficiaries into managed care plans, and as a result many thousands of homeless people have recently become members of Medi-Cal managed care plans. Medi-Cal expansion provides new federal funding to cover some costs that had previously been a County responsibility, though the State recovers 80% of the County's net new revenue through an offsetting reduction in health realignment revenue. Moreover, expansion increases access to regular ongoing health care for many low-income adults who had been uninsured.

Changes now underway also create opportunities and incentives to use health care resources in new ways. The County has tools to build the capacity of its delivery systems and service providers. County hospitals and safety net clinics must meet new performance metrics to receive financial incentives with these payment mechanisms the ACA and the State are building into Medi-Cal. Medi-Cal managed care plans have responsibility for ensuring access and coordination of care for a new group of members, including many of the people who are experiencing homelessness or living in supportive housing, while also managing financial risk, and presenting opportunities to collaborate with other managed care plans.

Some people who experience homelessness require affordable housing combined with intensive case management and various supportive services to help them obtain and keep housing ("permanent supportive housing" or PSH), or short-term services linked to other forms of housing assistance such as rapid re-housing. If barriers to housing stability are related to health, or mental health, or substance use disorder conditions, Medi-Cal or other health care system resources can pay for some of these services. Plenty of evidence demonstrates high costs for crisis services, which some chronically homeless people incur.[2] Opportunities exist to achieve savings in health system costs, better health outcomes, and a better experience for county residents when high-cost homeless people move into housing (compared to people continuing to live on the streets and experience repeated crises). The shift toward value-based purchasing and the ability to measure, report and reward quality in health care service delivery[3] creates incentives/opportunities for health care systems to help pay for services that connect health care systems' most vulnerable and high cost members to housing.

[2] See http://www.endhomelessness.org/pages/cost_of_homelessness

[3] An example of a source of information regarding widely-adopted quality measures can be found at http://www.qualitymeasures.ahrq.gov/browse/nqf-endorsed.aspx.

Preventing and ending homelessness need to be part of the overall efforts to reduce health disparities, particularly for African Americans. In discussions about using the resources of health systems as solutions to homelessness, policymakers have placed greatest focus on chronic homelessness and frequent users of high-cost health services, but data demonstrate correlations between homelessness overall and health disparities. Data show disproportionately high rates of homelessness among African Americans living in poverty. Similarly, African Americans receiving public benefits in Los Angeles County have disproportionately high rates of homelessness.[4] Evidence shows these disproportionately high rates apply to families with children, chronically homeless single adults, and people who experience repeated episodes of homelessness. Similarly, the stresses and risks associated with housing instability and homelessness compound the long-term health risks associated with adverse childhood experiences and the conditions that contribute to poor health and premature mortality in some communities of concentrated poverty. One implication is that health care systems and providers serving extremely low income people need to pay more attention to the impacts of housing crises on health and health care service utilization, as their members/patients may move in and out of homelessness and housing stability. As health care providers, delivery systems, and their partners seek to reduce health disparities, they should pursue opportunities to understand and partner with rapid re-housing interventions and supportive housing to create stronger linkages between health care delivery systems and access to housing via a coordinated entry system.

Current Efforts

Significant efforts are underway across the County, City and at the community-based level to leverage funding/programmatic opportunities currently now available under the ACA.

County

- **Housing for Health (HFH):** The County Department of Health Services (DHS) launched HFH in November 2012 to provide services and housing assistance for homeless individuals who have complex health, mental health, and/or substance use needs and are high-users of DHS hospital services. DHS utilizes a variety of community-based supportive housing options, including single family homes, individual apartments, blocks of apartment units, or entire buildings. DHS administers a rental housing component of HFH through the Flexible Housing Subsidy Pool (FHSP). DHS launched the FHSP with funding from DHS and the Hilton Foundation. The Los Angeles County Board of Supervisors (discretionary funding), the County Probation

[4] A recent Economic Roundtable analysis examined rates of homelessness among public assistance beneficiaries in Los Angeles, finding African Americans receiving a range of benefits (General Relief, CalWORKS, Food Stamps, and Medi-Cal) experiencing disproportionately high rates of homelessness. http://economicrt.org/publication/all-alone/(p. 16, figure 6).

Department, and the Department of Mental Health have also contributed funding. The FHSP locates housing and provides move-in assistance and rental subsidies. HFH also uses other housing resources, such as Housing Choice Vouchers provided by the Housing Authority of the City of Los Angeles, Continuum of Care (previously referred to as Shelter + Care) through the Los Angeles Housing Services Authority (LAHSA), and units of affordable or supportive housing created through other funding sources and made available to people receiving services funded through HFH. Indeed, HFH funds a flexible array of services, including intensive case management, crisis intervention, linkages to health, mental health, and substance use disorder services, assistance with benefits, housing search assistance for those who use tenant-based rent subsidies, and life skills and job skills training. HFH also funds interim housing options, including recuperative (respite) care to provide short-term stability for some homeless people experiencing chronic illness or recovering from hospitalization until they can move into permanent housing. Since the inception of the program in 2012, HFH has housed 1,035 County patients, 92% of whom have retained housing after 12 months.

- Single Adult Model: Beginning in the 2014-2015 fiscal year, the Board of Supervisors reallocated ongoing Homelessness Prevention Initiative (HPI) funding to implement a new Single Adult Model (SAM), which includes several components that seek to align more effectively outreach, health, mental health, SUD and housing assistance for single adults experiencing homelessness who are high-users of health and mental health services. New or re-structured programs include Multi-disciplinary Integrated Teams (MITs) to provide street and shelter-based intensive engagement and support, integrated mental health, health, and SUD services, ongoing case management, and connections to housing assistance for homeless persons with serious mental illness.
- Homeless Families Solutions System (HFSS): LAHSA launched HFSS in 2013 with County and City financial support. HFSS provides a regional system to address family homelessness by re-housing families quickly and efficiently and connecting families to supportive services within their communities. The 211 hotline, the emergency shelter system, MITs or other outreach and engagement teams, and the Department of Public Social Services (DPSS) connect homeless families to a family solutions center (FSC) within one of the eight geographic service areas. FSCs assess and triage families for an array of supportive services including medical and mental health services, SUD, disability benefits advocacy, crisis housing, diversion services, rapid-rehousing, employment development, legal services, child care, and PSH.
- Health Neighborhoods: The Department of Mental Health (DMH) is developing health neighborhoods to improve coordination of services for behavioral and personal health and address social determinants of health,

such as poor housing and poverty. The initiative is intended to create neighborhood collaboratives of health, mental health, and SUD providers to establish local partnerships to promote the integration of Whole Person Care. DMH is currently piloting Health Neighborhoods in seven Service Planning Areas. The LA Care Health Plan is also establishing a Health Neighborhood program in several of these communities to provide integrated care to homeless LA Care members.

- Analysis of Cost Outlays for Services to Homeless Individuals: The Chief Executive Office's Research and Evaluation Services will identify homeless individuals and the costs associated with their patterns of service utilization across multiple County systems. The data identifying homeless adults will be extracted from three sources: 1) the Homeless Management Information System (HMIS), 2) DPSS's Los Angeles Eligibility Automated Determinations, Evaluation and Reporting (LEADER) system, and 3) service records available from DHS. This data repository of homeless individuals will be matched against service records provided over fiscal year 2014-15 by seven County departments using the Enterprise Linkages Project that de-identifies client records, yet enables accurate linking through encryption software. Once completed, the CEO's Research and Evaluation Services will produce a similar report for homeless families.
- Planning for More Integrated Services and the Changing Role of Los Angeles County Health Departments :
    - Recently, the County Board of Supervisors passed a motion to establish a new jail diversion program,[5] which included a new Office of Diversion Re-entry within DHS. In August 2015, the Board of Supervisors approved plans to unite all three health departments (DHS, Department of Public Health (DPH), and DMH) under a single health agency, with the intent to integrate services offered through these departments. The vision of the integration of these departments is to offer whole-person-oriented care. On September 29th, the Board approved the following priority (among other priorities for the health agency): Developing a consistent method for identifying and engaging homeless clients and those at risk of homelessness across the three departments and linking these clients to integrated health services, housing them, and providing ongoing community and other supports required for recovery. The Health Agency Steering Committee overseeing the integration delineated the following goals:
        - Evaluating and reconfiguring housing and homeless services;
        - Developing an accurate way to identify homeless clients served across the three departments;
        - Develop and implement shared standards and practices;
        - Expand multidisciplinary street engagement teams;

[5] See *Statement of Proceedings for the Regular Meeting of the Board of Supervisors of the County of Los Angeles*, Sept. 8, 2015. http://file.lacounty.gov/bos/sop/cms1_233587.pdf.

- Develop and open a range of bridge programs to offer low-barrier interim options while clients wait for permanent housing;
- Maintain a real-time inventory of available residential slots;
- Link homeless people to integrated care;
- Develop screening questions for "those conditions that lead to homelessness;" and
- Develop policies and technical assistance to advance the availability of housing.[6]

City of Los Angeles

- **Potential City Participation in HFH:** While health, mental health and SUD services are primarily the responsibility of the County, the City of Los Angeles also has a significant role and faces substantial costs, including the costs of public safety responses (police and fire department), when homeless people experience health and mental health and/or SUD crises. Members of the City Council have recognized the value of the DHS HFH program and directed the Chief Administrative Officer to determine the feasibility of accessing or contributing City funding to pay into the FHSP.

Other Local Efforts

- **LAHSA Data-Sharing**: LAHSA has undertaken preliminary work to share HMIS data with LA Care's membership data, which will allow LA Care to identify many of their homeless Medi-Cal members. LA Care is believed to have the bulk of Medi-Cal beneficiaries experiencing homelessness in the County, but these efforts could be replicated with HealthNet, the other Medi-Cal managed care plan in the County.
- **Supportive Housing Partnerships with Federally Qualified Health Centers (FQHCs):** PSH providers continue efforts to form partnerships with FQHCs and other community clinics to improve care for formerly homeless tenants. A growing number of PSH developments include satellite clinics. For instance, JWCH operates a clinic in a Downtown Women's Center project and a County outpatient clinic connected to HFH is located at the Star Apartments.
- **Coordinated Entry System (CES):** Each SPA now has a functioning CES to prioritize the most vulnerable and chronically homeless people for access to PSH. CES provides assistance enrolling people onto Medi-Cal.

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[6] See *Agenda for the Regular Meeting of the Board of Supervisors of the County of Los Angeles*, Sept. 29, 2015, Recommendation 14, at http://bos.co.la.ca.us/LinkClick.aspx?fileticket=xm3KBb-ztkc%3d&portalid=1. See also *Letter from Interim Chief Executive Officer Sachi Hamai, Approve the Strategic Priorities and Operational Framework for the Los Angeles County Health Agency*, Sept. 29, 2015, at http://file.lacounty.gov/bos/supdocs/97833.pdf.

- **Health Home Capacity Building:** The Corporation for Supportive Housing is offering capacity-building training to get providers ready to become health homes under a potential new "Health Home" benefit California is working to create.

Comparative Perspective/Best Practices

Federal Guidance

The Federal Strategic Plan to Prevent and End Homelessness has established the goals of ending veteran homelessness in 2015, ending chronic homelessness in 2017, and ending homelessness for families with children in 2020. To achieve these goals, the federal plan includes several strategies related to connecting health and housing:

- Increase use of mainstream resources to cover and finance services in PSH.
- Encourage partnerships between housing providers and health and behavioral health care providers, such as health centers, to co-locate, coordinate, or integrate health, behavioral health, safety, and wellness services with housing and create better resources for providers to connect patients to housing resources.
- Build upon successful and test new care and service delivery models.
- Advance health and housing stability for people experiencing homelessness who have frequent contact with hospitals and the criminal justice system.

The Centers for Medicare and Medicaid Services (CMS) recently issued guidance to state Medicaid directors through an Informational Bulletin that describes some options for using Medicaid to pay for housing-related activities and services for persons with disabilities, including people who are homeless, such as housing assessments, assisting in securing housing, and completing housing applications and securing required documents. The CMS guidance indicates Medicaid cannot pay for the costs of housing ("room and board").[7] For individuals transitioning out of Medicaid funded institutions or other provider-operated living arrangements to a private residence where the individual is responsible for his/her own living expenses, Medicaid can fund supports to enable an individual to establish a household. Medicaid can fund, for example, security deposits, fees for utility connections, household furniture, moving expenses, window coverings, and kitchen items. CMS expects to release additional guidance regarding Medicaid reimbursement for services for chronically homeless persons. This Informational Bulletin falls on the heels of 2014 case studies and a primer that the Department

[7] See www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

of Health and Human Services (HHS) published for using Medicaid to pay for services in PSH for chronically homeless persons.

The Department of Housing and Urban Development (HUD) and HHS, in collaboration with the US Interagency Council on Homelessness (USICH), launched a joint technical assistance initiative called H2 to support states and communities in undertaking the systems changes needed to enhance integration and collaboration between the housing and healthcare systems. The goal is to maximize care coverage for the target populations and increase access to comprehensive healthcare and supportive services, coordinated with housing.[8]

Nationwide, communities are targeting PSH to the most vulnerable and/or high-cost homeless people and people who have been homeless the longest, in response to guidance and encouragement from HUD, USICH, and other federal agencies and national advocacy. Communities are implementing coordinated entry systems that prioritize these individuals for housing and make it easier for health plans and providers to connect with homeless assistance and housing resources for their most vulnerable and high-cost patients/members.

HUD is encouraging communities to allocate resources to implement or expand rapid re-housing programs that provide time-limited services and financial assistance to get people back into housing quickly and help them make connections to community support. Communities are urged to re-evaluate and consider reducing the use of resources in the homeless system to pay for long-term, transitional homeless programs that are separate from other services for low-income people. The expansion of rapid-rehousing approaches provides new opportunities for collaboration between health care and homeless assistance systems, as new forms of housing assistance become available to people experiencing housing crises, and as these families and individuals need to make effective connections to community services that can help them address ongoing health, mental health and SUD conditions and offer supports to overcome barriers to housing stability.

Discussion Questions

How can the reach of HFH be expanded?

- How can the County foster greater participation in the FHSP, potentially drawing contributions from managed care health plans, other County agencies, and cities, as well as other local jurisdictions?

[8] See www.hudexchange.info/programs/aca/

- How can the FHSP and the supportive services and interim housing resources provided through HFH be linked to housing subsidies administered by public housing authorities, to better leverage those resources for ongoing housing costs?
- How can the County bring State and federal resources to expand the reach of HFH, either by accessing additional sources of revenue for services or rental subsidies or better aligning existing resources?
- Can/should HFH serve homeless County residents who meet consistent eligibility criteria around frequent use of crisis care (not only those who use County hospitals)? If so, how could the associated costs be funded?

What types of housing-related supports and/or interim housing can be financed or leveraged through Medi-Cal, other provisions of the ACA, or other mainstream health programs, and how can these resources be used to rehouse homeless adults and families?

- How can the County, City, health, homeless services, housing, and CES/FSC providers use new and expanded Medi-Cal benefits (such as Drug Medi-Cal and health home benefits) and potential funding from the 1115 Waiver to maximize the effectiveness of prioritizing housing and services resources for the most vulnerable homeless residents through CES and HFSS?
- As Los Angeles County designs a new delivery system using benefits available under the Drug Medi-Cal Waiver amendment, Substance Abuse and Mental Health Services Administration (SAMHSA) block grants, and other SUD treatment resources, what expertise and capacity will be needed by SUD providers to effectively engage homeless clients and support linkage to housing?
- Can the Drug Medi-Cal Organized Delivery System Waiver offer opportunities to use other flexible SUD treatment dollars to fund interim or permanent housing?
- What types of partnerships and commitments between County, managed care plans, and community-based organizations are needed to strengthen housing assistance and retention for the most vulnerable homeless residents?

How can the County promote integrated care for residents experiencing homelessness?

- How can medical, mental health, and SUD treatment services be effectively integrated for people experiencing homelessness or for formerly homeless now housed residents on Medi-Cal?
- Can County departments, such as DPSS and the Sheriff, offer access points to integrated care? If so, how?

- Could a Medi-Cal funded integrated health/mental health/SUD assessment be provided to all homeless families and individuals upon initial contact with the County service delivery system? If so, how would that assessment relate to the current CES assessment tool? If so, could that assessment be used to determine the appropriate service path for that individual/family, including whether the individual/family should pursue employment or SSI/veterans' disability benefits?

Resources

Are there dollars that Los Angeles County and/or cities are currently spending to serve homeless individuals/families which could instead be used to pay for housing?

- Both the County and cities spend significant resources, much of which are health-related costs, in crisis interventions for people experiencing homelessness.[9]
- The County currently spends Continuum of Care money for services that it could spend instead on housing, if the Health Home benefit funding under the 1115 Waiver, or Drug Medi-Cal waiver amendment, or other Medi-Cal financing approaches could fund more services in housing.
- The HFH program currently funds services, and some of this funding could be re-directed to pay for additional housing, if a new Medi-Cal Health Home benefit or Drug-Medi-Cal Waiver amendment could reimburse some of the services the program provides. For example, the County could respond to Medi-Cal managed care plans who issue requests for proposals, to become a lead community-based care management entity (health home) and use existing HFH contractors to provide health home services. A County-led health home could increase capacity to deliver health home services Countywide, expand the reach of HFH, and allow the County to redirect resources.

Is there additional revenue which Los Angeles County and/or cities could generate to pay for or reimburse the costs of housing?

- The County and City could work with LA Care, LA Care's subcontracted health plans, and HealthNet to create regional partnerships. The partnerships could track data to determine cost savings that are achieved by moving high-cost homeless beneficiaries into housing, and then use a portion of those savings to pay for recuperative care, interim housing,

[9] D. Flaming, P. Burns & M. Matsunaga. "Where We Sleep: Costs When Homeless & Housed in Los Angeles." *Economic Roundtable.* 2009 (reporting data showing costs of an LA County homeless resident on General Relief average $2,897 per month, with almost two-thirds of costs incurred in health care crisis services).

security deposits, and long-term rental subsidies. Under the 1115 Medicaid Waiver housing and Whole-Person Care proposals (the coordination of health, mental health, and social services in a patient-centered context to achieve the Triple Aim, which is currently being negotiated under the 1115 Medicaid Waiver), incentives may be available to create the partnerships. A health plan's contributions to a regional partnership may be considered costs of care under the housing proposal of the Waiver.

Legislative Advocacy

Are there any changes in State or federal law or regulations which should be pursued?

- The County could advocate with the State Department of Health Care Services (DHCS) to ensure DHCS designs the health home benefit to:
  - Provide an adequate per member, per month rate to offer intensive services to homeless beneficiaries;
  - Limit administrative burden; and
  - Allow for services promoting housing stability.
- Over the next weeks, the County and cities could advocate on the State's behalf with CMS to approve 1115 Medicaid Waiver proposals that would provide some federal funding for some housing and services costs, and then work with DHCS to implement final Waiver provisions.
- The County and cities could advocate with the Governor, State Legislature, and California congressional delegation for greater State and federal investment in housing people in deep poverty, including people experiencing homelessness, using the argument that such funding is a health intervention.

Potential Policy Options

- **Health Homes:** Use the health home benefit as a major source of sustainable funding for services to move vulnerable populations into housing, and keep vulnerable homeless people stably housed. The ACA included an optional Medicaid benefit states can access to provide "health home services" to Medicaid beneficiaries with chronic health conditions. Health home services include comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, referral to community and social supports, and use of health information exchange. DHCS is now working to craft a health home benefit in California that will serve people with eligible chronic conditions experiencing homelessness, among other populations. The new benefit will become available in July 2016.

Advocates are working with DHCS to define services in a way that allows service providers to access Medi-Cal payment for outreach, engagement, linkage to housing, discharge planning, case management promoting housing stability, and other services typically offered in supportive housing. A new health home benefit could, if implemented correctly, offer a sustainable source of funding for many supportive housing services and could significantly increase funding for services available in the County's HFH program.

- **1115 Medicaid Waiver:** Assess and take advantage of opportunities under the 1115 Medicaid Waiver to use Medi-Cal to fund recuperative care, security deposits, and interim housing.
    - California is currently negotiating with CMS to reach agreement on an 1115 Medicaid Waiver. These waivers allow states to incorporate innovations over five years, provided the innovations are budget neutral to the federal government. California proposed innovations in funding housing, housing-based services, and Whole Person Care pilots. By November 2015, CMS and California are scheduled to adopt final Waiver special terms and conditions.
    - Under the Housing and Housing-Related Services proposal, the State would authorize Medi-Cal managed care plans to count as costs of care services promoting housing stability. The proposal would also allow health plans to consider as costs of care contributions to a regional housing pool. The plans would add contributions from projected savings from moving Medi-Cal beneficiaries from homelessness to housing. Counties and other partners would also contribute funds to the regional housing pool. Regional housing pools could fund security deposits, interim housing, and recuperative care. Eligible Medi-Cal beneficiaries would include people experiencing homelessness or at risk of homelessness upon discharge from institutional settings. DHCS has proposed using the pool to fund long-term rental subsidies; CMS, however, is not likely to adopt this proposal.
    - Similarly, under the Whole-Person Care 1115 Waiver proposal, counties could develop innovative models to track data of residents incurring high county costs, identify populations incurring those costs, and form partnerships to pool county and health plan dollars to fund innovations that decrease county health care costs. Both of these proposals may change significantly as the state negotiates the terms of the waiver with the federal government. CMS has rejected the state's proposed approach to calculating "shared savings" and credit for contributions to match federal funding in several proposals for the 1115 Waiver.
- **Drug Medi-Cal/Organized Delivery System:** Use the Drug-Medi-Cal Waiver amendment (also referred to as the Drug Medi-Cal Organized

Delivery System Waiver) to provide evidence-based SUD treatment and recovery services to vulnerable homeless County residents and residents of supportive and affordable housing, and shift other, more flexible funding sources now used for services (i.e., federal block grant funds) to deliver substance use and other services to formerly homeless people living in housing and for some housing assistance, including interim and low-barrier housing.

- CMS approved an amendment to the existing 1115 Medicaid Waiver for a Drug Medi-Cal Organized Delivery System. Under the direction of DPH's Substance Abuse Prevention and Control division (SAPC), Los Angeles County is working to opt into this new organized delivery system. SAPC initiated a regional planning process in mid-August 2015 that convened stakeholder meetings across the County to discuss the objectives of the implementation plan and to receive feedback in the areas of beneficiary access, adult and adolescent benefit packages, residential authorizations, assessment and medical necessity, quality assurance, and other components of care.
- Los Angeles County could choose to offer the following benefits to beneficiaries experiencing substance use disorders:
  - Case management that coordinates health care and social services;
  - Withdrawal management;
  - Residential treatment in a licensed facility;
  - Intensive outpatient treatment (also known as day care habilitative treatment);
  - Outpatient treatment in a licensed facility;
  - Medically-assisted treatment;
  - Recovery monitoring;
  - Education and job skills;
  - Family support;
  - Support groups; and
  - Ancillary services.
- Providers will be required to offer treatment based on evidence-based models and often in licensed facilities. DHCS indicated in the Waiver amendment an intent to allow counties to use federal Substance Abuse Prevention and Treatment Block Grant funds to pay for the costs of recovery residences. Alternatively, as Medi-Cal will fund more of the services the County now pays for through these block grant dollars, opportunities may exist to shift these dollars to fund services Medi-Cal does not now fund, like outreach and engagement, and couple these services with housing assistance,

and/or to use some of these flexible dollars for low-barrier interim and permanent housing assistance.

- **Creation of Partnerships:** Create County, LAHSA, and Medi-Cal managed care plan partnerships in a coordinated way to:
  - Identify high-cost homeless members;
  - Work toward participation of the plans as partners in HFH, with the ultimate goal of providing health plan funding for services in housing, recuperative/respite care, and potentially interim housing costs;
  - Avoid the problem of Medi-Cal beneficiary frequent managed care plan changes by creating a regional structure that allows plans to contribute funding for managed care plan members meeting specific eligibility criteria;
  - Connect tenants to long-term support services, such as palliative care, in-home supportive services, and assisted living services; and
  - Collect cost-avoidance data.
- **CES/HFSS/SAM:** Align coordinated entry systems to do the following:
  - Connect people experiencing homelessness to health care providers and health plans and to connect homeless patients to housing resources; and
  - Align assessments to prioritize for PSH people eligible for programs like the Medi-Cal health home benefit, which will base eligibility on a combination of chronic conditions.